Hope's Playground Pediatric Therapy

NEW PATIENT INTAKE FORM

Today's date:_____

Completed by:_____

GENERAL INFORMATION:

Child's name:_____
Date of birth:_____ Male____ Female____
Address:_____
Street City State Zip
Email Address:_____
Mother's name:_____
Mother's phone number:_____
Home Cell Work
Father's name:_____
Father's phone number:_____
Home Cell Work
Insurance carrier's name:_____
Insurance carrier's date of birth:_____
Child's medical diagnosis:_____
Referral source:_____
Primary physician:_____
Physician's address:_____
Physician's phone:_____
Other physicians who provide care:
Name: Type of specialist:
_____ _____
_____ _____
Does your child have any siblings? Please list name(s) and date(s) of birth.
_____
_____
Is there any history of learning, neurological, psychological or hereditary problems in the immediate family or mother's/father's families?

Yes____ No____
Comments:_____
_____

Language spoken at home:_____

HEALTH AND MEDICAL HISTORY:

What is and has been your child's general health condition?

_____

_____

_____

Please list names and schedule of medications your child is currently taking:

_____

_____

_____

Has your child ever had a seizure? Yes____ No____

Comments:

_____

_____

_____

Has your child ever been hospitalized? Yes____ No____

At what age and for what reason?

_____

_____

_____

Does your child have any known allergies? Yes____ No____

Please list:

_____

_____

_____

Is your child on a special diet? Yes____ No____

Comments:

_____

_____

_____

Has your child ever had an ear infection? How frequently?

_____

_____

Has your child ever had a hearing test? Yes_____ No_____

If yes when?_____

Has your child ever had a vision test? _____

Visual Impairments/Comments_____

_____

PRENATAL AND BIRTH HISTORY:

Did the mother have any complications during pregnancy or delivery? Yes____ No____

Comments:_____

_____

_____

Length of pregnancy:_____ Duration of labor:_____

Type of delivery:_____ Birth weight:_____

How long did the child remain in hospital?_____

DEVELOPMENTAL HISTORY:

Please list **approximate** age of your child when he or she accomplished the following:

Smiled _____ Started solid foods_____

Followed objects with eyes _____ Drank from a cup_____

Rolled over_____ Fed self_____

Sat alone _____ Dressed self_____

Crawled _____ Had bladder control_____

Stood alone_____ Had bowel control_____

Walked_____ Said first word_____

What are your current concerns regarding your child's speech and language?

_____

_____

_____

What are your current concerns regarding your child's feeding/eating?

_____

_____

_____

What are your current concerns regarding your child's fine motor skills?

_____

_____

_____

What are your current concerns regarding your child's sensory processing skills?

_____

_____

_____

What are your current concerns regarding your child's gross motor skills?

_____

_____

_____

Does your child wear orthotics on his or her arms/hands or legs/feet? When are these worn (i.e. day, night)?

_____

_____

_____

What are your current concerns regarding your child's behavior?

_____

_____

_____

Please list any therapy services your child is currently receiving. Are services provided in a clinic, school, and/or home?

_____

_____

Did your child receive any therapy services in the past?

_____

Does your child attend school? Yes_____ No_____ If yes, please list name of school

_____

Is there anything else you would like us to know about your child?

_____

_____

_____

Thank you for taking the time to complete this form. This information will assist us in providing the most accurate evaluation possible. If you have any questions or concerns regarding your child's evaluation, please don't hesitate to discuss this with your therapist or any of our staff. We strive to provide the best care that we can for you and your child! Thanks again!

Hope's Playground